



**SARRELL REGIONAL DENTAL CENTER FOR PUBLIC HEALTH, INC.
ATHENS OFFICE**

DISCOUNTED/SLIDING FEE APPLICATION

Office Policy

It is the policy of **Sarrell Regional Dental Center for Public Health, Inc. - Athens Office**, to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family income and size. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services, which are received from another **Sarrell Regional Dental Center for Public Health, Inc. office** or other outside facilities, including reference laboratory orders and other such orders. In the hope that your financial situation improves, discounts apply to current, not future services. Please inquire at the front desk if you have questions.

Total Household Income

⇒ Number of related persons living in your household: _____

⇒ Please complete **ONE** of the columns below to establish your *Total Household Income*.

Household Member	Annual	Monthly	Bi-Weekly
Self			
Spouse			
Dependents under age 18			
Total			

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veterans payments, new business or self employment, alimony, child support, military, unemployment and public aid.

⇒ I certify that the family size and income information shown above is correct. I understand that copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

X _____
X _____
Date: ____ / ____ / ____
Name (Print)
Signature

Office Use Only	
Patient Name: _____	Discount: _____
Date of Service: _____	Approved by: _____



Household Information

Name of Head of Household: _____
 Street: _____
 City: _____
 Relation to Patient: _____

Health Insurance Provider: _____
 Place of Employment: _____
 State: _____ Zip: _____
 Phone: _____
 Social Security Number: _____

Dependent Information

↳ **Please list spouse and dependents under age 18**

Patient Name: _____
 ▶ Date of Birth: ___ / ___ / ___
 Spouse: _____
 ▶ Date of Birth: ___ / ___ / ___
 Dependent: _____
 ▶ Date of Birth: ___ / ___ / ___
 Dependent: _____
 ▶ Date of Birth: ___ / ___ / ___

Dependent: _____
 ▶ Date of Birth: ___ / ___ / ___
 Dependent: _____
 ▶ Date of Birth: ___ / ___ / ___
 Dependent: _____
 ▶ Date of Birth: ___ / ___ / ___
 Dependent: _____
 ▶ Date of Birth: ___ / ___ / ___

Annual Household Income

Source	Self	+	Spouse	+	Other	=	Total
Gross wages, salaries, tips, etc.							
Social Security, pension, annuity & veterans benefits							
Alimony, child support, military family allotments							
Income from business self employment and dependents							
Rent, interest, dividend & other income							
Total Income							

Verification Checklist

↳ **Please provide copies of one of each of the listed items.**

- | | YES | NO |
|--|-----------------------|-----------------------|
| ▶ Identification/Address: Driver's License, birth certificate, employment ID, social security or other | <input type="radio"/> | <input type="radio"/> |
| ▶ Income: Prior year tax return, three most recent pay stubs, or other | <input type="radio"/> | <input type="radio"/> |
| ▶ Insurance: Insurance card(s) | <input type="radio"/> | <input type="radio"/> |
| ▶ Medicaid: Application made or evidence of rejection | <input type="radio"/> | <input type="radio"/> |

I certify that the above information shown above is correct and understand verification is required for approval.

X _____ **X** _____ Date: ___ / ___ / ___
 Name (Print) Signature

Office Use Only

Pay Class Approved: _____ Effective Date: _____
 Approved by: _____ Expiration Date: _____